Dr. Mark Shelley

# The Commoditization of Health Care

*Dr. Mark Shelley gave this speech at the Schiller Institute's conference on the New Paradigm on Jan. 26, 2013. On Oct. 24, Dr. Shelley issued a call, "Doctors Against Murderous Obamacare," to rally the medical profession against the philosophy and practice which he herein describes.*

I'm a family physician, and I practice in a very rural area of Pennsylvania. A family practice is a specialty; it's a specialty of being a generalist, and our position is to assimilate all the parts of a patient, and holistically take care of the heart, lungs, brain, toes, and either keep or make the patient well.

As I've done this for a while, I think I can apply that perspective to looking at the functioning of your health-care system. There are some serious flaws, and I think all of you understand that our current health-care system has not been kept well. So, what shall we do? If we can't keep it well, we'll make it well, or try.

So, approaching this as I might one of the other problems I would have in my everyday life, I'll make a diagnosis. So we say, "Well, what's wrong with health care? What's wrong with it?"

I think most of us understand the quality is low and the price is high. We're paying gourmet prices for vending-machine food.

Recently, a 378-page report, which was entitled "Shorter Lives, Poorer Health," was published by the National Academies Press. This found that we spend $9,000 [on medical care] per capita—this is as of 2012—which is two and a half times the OECD average as a percent of GDP. We spend 17.6% of our massive GDP on health care.

This organization of countries, the OECD, includes the U.S., the EU, but also Turkey and Mexico, countries that we may not routinely expect to have better health care than we do, or at least, health care at a better value. Because in the United States, there are fewer physicians per 1,000 population, at 2.4, than there are in the OECD average at 3.3 per thousand. There are fewer physicians' visits—4, compared to 6.4—here, as compared to the OECD. And fewer and shorter hospital stays.

Markers of wellness in the United States—for example, life expectancy, infant mortality, incidence of diabetes, obesity—these markers have all shown steady deterioriation in the last decade. Children born today are projected to have a shorter life-expectancy than their parents, reversing a trend of many centuries.

Maybe this is the complaint of the patient. This is a description of the problem.

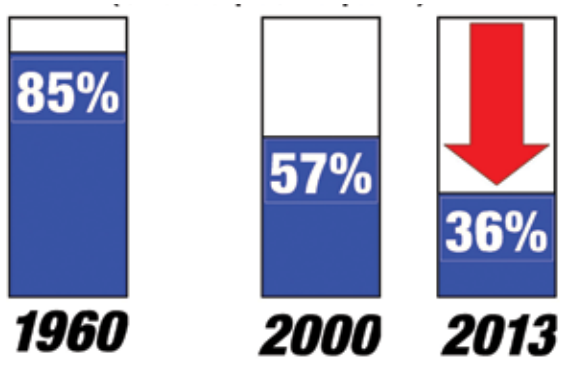

EIRNS/Stuart Lewis

*Dr. Mark Shelley, a family physician from rural Pennsylvania: Doctors are being forced, by the monetization of health care, to violate their Hippocratic Oath. As a result, people are dying.*

FIGURE 1

**Percent of Physicians Who Are Independent**

(own at least part of their practice)




## What Is the Diagnosis?

We have to find out why. What happened? What's the diagnosis? Try to generate data, and use logic, persevere, and I think we can have a diagnosis. I know it's popular to blame your physician. I know that real well.

But your physician does not determine how, if, when, or what your care will be. In the year 2000, 57% of the nation's 682,470 physicians had a stake in the practice in which they treated patients—they owned the practice; they had at least a partial ownership. And they were generally their own bosses, to a certain extent, at least. And the buck stopped pretty much close to there. Socrates said privilege flows from responsibility, and we were able to acknowledge that.

In 1960, 85% of physicians worked for themselves (**Figure 1**); by 2000, 57%; by 2013, 36% of physicians worked for themselves. This trend is not about to stop. I believe that in 2000, 3% of physicians graduating from residencies, listed hospital employment as their primary choice, and that number is almost 40% today. The profession is leaving independent practice in droves.

So, who do they work for? They're treating you, the patient—ultimately the physician works for the patient, we hope. But these physicians are employed by hospitals, as was mentioned, maybe insurance companies, and multinationals. These are one and another company or organization which must be fed money. They exist for money—this is what they live on—and they need a lot of money.

This guy (**Figure 2**) didn't have an 85% overhead, okay? And he probably treated the doll for free, too.

I don't know if you can read this or not (**Figure 3**).

FIGURE 2

**"The Doctor and the Doll" (Norman Rockwell, 1929)**

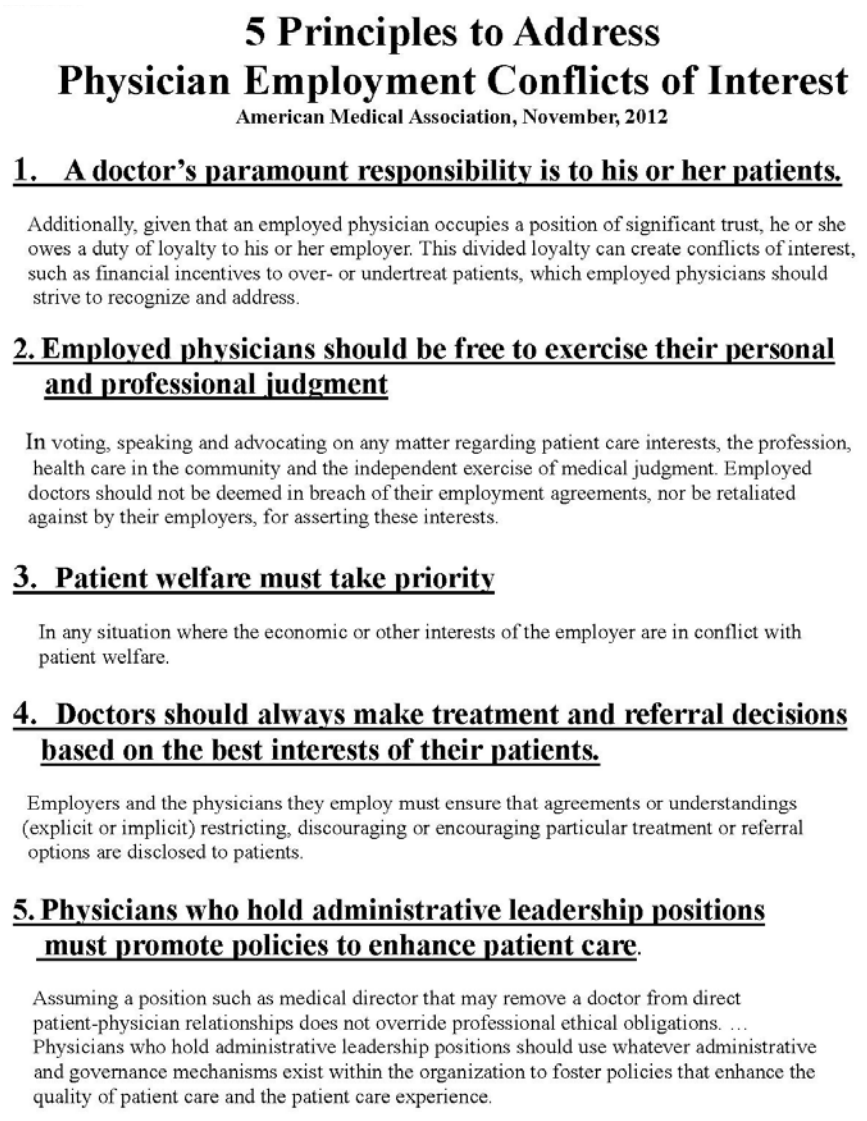
FIGURE 3

**Medical Marketplace Conflomerates**

Of For-Profit Hospitals, Physicians, Services

FIGURE 4

**Five Principles To Address Physician Employment Conflicts of Interest**



5 Principles to Address
Physician Employment Conflicts of Interest

American Medical Association, November, 2012

1. A doctor's paramount responsibility is to his or her patients.

Additionally, given that an employed physician occupies a position of significant trust, he or she owes a duty of loyalty to his or her employer. This divided loyalty can create conflicts of interest, such as financial incentives to over- or undertreat patients, which employed physicians should strive to recognize and address.

2. Employed physicians should be free to exercise their personal and professional judgment

In voting, speaking and advocating on any matter regarding patient care interests, the profession, health care in the community and the independent exercise of medical judgment. Employed doctors should not be deemed in breach of their employment agreements, nor be retaliated against by their employers, for asserting these interests.

3. Patient welfare must take priority

In any situation where the economic or other interests of the employer are in conflict with patient welfare.

4. Doctors should always make treatment and referral decisions based on the best interests of their patients.

Employers and the physicians they employ must ensure that agreements or understandings (explicit or implicit) restricting, discouraging or encouraging particular treatment or referral options are disclosed to patients.

5. Physicians who hold administrative leadership positions must promote policies to enhance patient care.

Assuming a position such as medical director that may remove a doctor from direct patient-physician relationships does not override professional ethical obligations. … Physicians who hold administrative leadership positions should use whatever administrative and governance mechanisms exist within the organization to foster policies that enhance the quality of patient care and the patient care experience.

Source: American Medical Association, November 2012

These are the medical marketplace conglomerates. Some of the folks in Leesburg found these for me. The first is the Universal Health Services—they're in 36 states; they have 218 facilities, and their annual revenue [in 2011] is $7.5 billion. Health South Corporation is in all 50 states, making $2 billion. The next number, roughly $10 billion. The next number, $6 billion. These are the companies for whom your doctors work. Your doctor doesn't decide—your doctor has two masters. Your doctor has the Hippocratic Oath, or the intangible, and he has the paycheck writer. He has his boss.

This continues.

So, this creates a conflict of interest. We've heard the word conflict many times today—as in Vietnam conflict, or Korean conflict. This is a war. The best interest of the patient competes or conflicts with the best interest of the company. This struggle goes on within your physician, as he attempts to make you well. Really, physicians don't go to medical school in order to *not* make people well—they truly want to do this.

Now, the company has many means of coercion to win this conflict, this struggle, and they have the time and your money, and a lot of personnel, to apply these means. And this situation, this struggle, has manifested itself to such a degree, that it can no longer be ignored, which is obviously a first choice. But it's devolved to a degree that the American Medical Association, which is arguably the largest and most influential physician organization in the U.S., developed and published, in November 2012, what they called principles to address conflicts of interest (**Figure 4**).

There are five principles: Number one is listed as "A doctor's paramount responsibility to his or her patients." Additionally, given that an employed physician occupies a position of significant trust, he or she owes a duty of loyalty to his or her employer. This divided loyalty can create conflicts of interest, such as financial incentives to over- or undertreat patients, which employed physicians should strive to recognize and address.

When a person tries to give you a right, it means they really believe you don't have the right to start with.

Your doctor believes that his paramount responsi-

bility is to you, but his employer doesn't. The reason the AMA developed these principles, is because they've already been violated.

The second: "Employed physicians should be free to exercise their personal and professional judgment," in voting, speaking, and advocating on any matter involving patient-care interest. The professional health-care community should be able to exercise its own judgment in voting, speaking, and advocating on any matter.

Employed doctors should not be deemed in breach of their employment agreements, nor be retaliated against, by their employers for asserting these interests.

You're not stating this for no reason—this has been done. A lot.

Patient welfare must take priority. In any situation where the economic or other interest of the employer is in conflict, patient welfare must take priority. Doctors should always make treatment and referral decisions based on the best interests of their patients. Physicians who hold administrative leadership positions must promote policies to enhance patient care.

All these principles have already been violated. It doesn't feel good, as a physician.

So, we have the principles, and they've been published. Now, what happens with them? The problem goes away? No.

This is not a law. It has no real effect in the actual functioning of the system, and I suspect the problem will continue to devolve, just as it has in the past. The League of Nations, after World War I, had these righteous, but more or less ineffective or [un]useful statements.

So, you have a war. You have two sides. You have a conflict of interest. What are they? What are these two sides?

One is tangible, solid, the money, versus the intangible, which is identified by the Hippocratic Oath. It's a promise from the profession to the patient, a sense of duty; it's an intangible. So I really think that this conflict, this war, is at the basis of a lot of what we all experience, with our horribly, horribly broken health care system. The values are not there.

## It Began with the HMOs

How did it start? I'll try to give you a little history, try to flesh out with some data, how exactly I believe this has happened.

In 1973, legislation was passed which allowed the formation of what have been called Health Maintenance Organizations [HMOs]. This was during the term of Richard Nixon. These organizations function generally by accepting a flat fee for generally a year, from the patient, or your employer—which is the same thing as from you. So this money is accepted, and then paid to providers, hospitals, laboratories, and physicians, and profit is kept for the company.

If the patient stays well, and requires no input, then everybody keeps their share of the money, and everything is fine. If the patient is not well, then all the providers, the care-providers, must spend the money they were given, and probably much more, because they're using the money from the patients who did not require care.

But if the patient was not well, and was not treated, the provider could keep the money. You just don't see those patients. They're just not taken care of. They're just denied care.

How do you deny care? There are a lot of ways. You can just pretend that you're trying to do the best, and there are many mechanisms for this. There's an inherent at-heart-based conflict of interest, and this has grown since 1973. The spirit, or an intangible, or the spirit of humanity, versus money, material.

And there's a war going on. I tell my 12-year-old—nobody wins the war. One side just loses less. When you see the failure of the health-care system, you see the cost of this war.

Some more interesting data: We all become isolated and project our values on others—I really didn't realize how little known some of these concepts were. In treating a patient, the physician has a reason for doing what he does. That's what he's learned, that's why he's gone to school. Like a mechanic who gets the manual for your make of car. It's the best he can do. And this is the result of studies which are done, science—this is the science that we turn to.

These studies are done by generating data, evaluating it, and reaching conclusions. Now, the process of doing the study, in case of a new drug, runs as follows. A large number of cases are divided into two groups: 500 people here, 500 there. 500 of these patients are given a medication, the other 500 are given a placebo, which is a sugar pill, or maybe a different medication. A course of time goes by, and there are measurable changes between the treated patients, and

the placebo patients. The measurements are taken, and subjected to statistical analysis, and the result of that analysis recommends or rejects the use of this medication.

Now, if the medication is used, it becomes profitable, sometimes very, very profitable. Often, with these patented medicines—I'm sure you have some sense of the incredible amount of money that's going into the pharmaceutical industry. With pure science, the funding source doesn't matter. But this testing is very expensive, and it's funded by different organizations, which may or may not have a financial stake in the outcome.

On Aug. 3, 2010, the *Annals of Internal Medicine* report analyzed 500 drug trials of the type I described above. And the result of each of these trials determined whether the drug should be used, to the profit of its maker, or not used, and the research and development would have been lost. Seventy-five percent of these 500 studies were funded by the industry, the pharmaceutical industry, and the rest by non-profit organizations. Our study of the studies was funded by people who will benefit from the drug being useful, and was funded by somebody who was unbiased.

The research funded by the industry was 85% positive, meaning these drugs would go on and be used and sold. That was six out of seven times. The studies funded by the non-profits were anywhere from 50 to 60% positive, roughly one out of two.

When the company will make a profit, will take much of your money, for the use of this drug, six out of seven times they're able to say yes. When nobody really profits, other than science and the patient, it's one out of two. That's unambiguous.

Now, 75% of these studies were funded by the pharmaceutical companies, because these companies obviously have a lot of money, and they have a lot of reason to make more. And there are many other ways that this happens.

What else is funded by this profit arm of the conflict?

## Standard of Care

Now, we practice according to a loose and general concept called a "standard of care." For example, the standard of care for a heart attack would be to hospitalize the patient, and give a course of medication and interventions. Now these standards change over time, as new procedures and drugs become available. For example, in 1980, we had clot-dissolving medications which became available, and became standard. And cardiac catheterization. Standards change.

This standard of care would have been determined by the American College of Cardiology. The standard of care for delivering is the American College of Obstetrics and Gynecology. So, each specialty society generates many clinical practice guidelines. A 2009 review of 14 American College of Cardiology guidelines, published by the *Journal of the AMA* by Tricoche, found that 11% were based on solid research, while nearly one-half were based on "expert consensus." This is where people sat down and issued an edict.

So, who are the edict-issuers? Were they paid by drug companies, to move to the point? Were these people paid by drug companies to issue this edict, this statement, that we all more or less have to follow, because they didn't do testing; they just decided. Well, Mendelsohn et al., in the *Archives of Internal Medicine*, 2011, reviewed 17 guidelines, with 498 contributors, and found that 56% had a conflict of interest. Newman and others, in the *British Medical Journal* [*BMJ*], 2011, reviewed 14 U.S. and Canadian clinical practice guidelines on diabetes and elevated blood cholesterol. Five of these 14 did not list conflicts of interest, which doesn't mean there was no conflict. They just didn't list them. In the nine which did have documentation, 50% of the authors had conflict of interest.

These people are deciding how you will be treated, and they're being paid.

A 2002 survey of 100 specialty guidelines revealed that 87% had ties to the pharmaceutical industry. That was Chowdury and others, in the *Journal of the AMA*, 2002.

This is my favorite, though. In the *BMJ* 2002, Lenzer and others described an allegedly non-profit organization, which issued a guideline recommending the use of a drug for stroke. Probably a group of neurology physicians said, okay, this is how we will treat stroke. This is the allegedly non-profit organization.

Now, this organization, this non-profit, received $11 million from the manufacturer of this drug. After they received the $11 million, they put six out of nine, two-

thirds—on a nine-member panel, six of these—and this 66% recommended the use of the drug, which is used when people are having strokes. It's very dangerous—the risk is high, and the benefit is high. It's not to be done lightly.

I know it's hard to follow, and because it's hard to follow, is why they can get away with it! Because it's a cult.

Now, take this data, which over and over again is corrupted, and your doctor will do the best he can, at the same time not offending his employer, because his employer will fire him, or not put any heat in his office, whatever. It's not good. And he orders a test. The test has to have what we call prior authorization, and the insurance company, to avoid paying for the test or treatments, will make you beg for this test. And it can take a day of phone calls back and forth, or it can take a month. That's another way that they limit what you can do, what I can do as a physician.

## 'Rational Utility'

This is the administrative cost (**Figure 5**). We spend 17.6% of our GDP on "health care." It's two and a half times as much as the OECD average. But 30% of that 17.6% is around 5%, and so we spend as much on the guys behind the desk, as the rest of the world spends on all their health care, as a percentage of GDP.

And there are 11 times as many administrators today as there were in 1980. The administrators—not only do they take your shrinking health-care dollar; they also are not trained. They're deciding what medicines I can use, what operating room equipment I can use, what bandages; and so, at that point, you're also suffering in your health care, the value of your health care, because of that.

If I was running a software company, it would fail. Why do we think health care should do any better? These people aren't trained, and they are deciding how you're treated.

How did this happen? How could these people treat other human beings, such as you and your kids, like this? And I propose that, to them, you are not considered a human being. You are viewed as a commodity, or an object. Like coal, or wheat, or sheep, to be bought, sold, and eventually land-filled. Your humanity has been monetized.

In 1949, Dr. Leo Alexander, in the aftermath of the genocide trials at Nuremberg, in attempting to understand how we as a species could undertake something as incomprehensible as these mass exterminations of what were known as "useless eaters," described the core philosophic principle which led to the atrocities. He called it "rational utility." Rational utility, of human beings. Obviously, objects.

FIGURE 5
**U.S. Health Dollar**
Administration Cost


Human beings are sorted and catalogued, depending upon their utility, like colored pebbles or cattle. And then, very rationally, culled out like lame cattle, or moldy apples.

And this was a long process, which required dehumanizing, or commodification, of human beings. To quote Dr. Alexander, "Whatever proportions these crimes eventually assumed, it became evident to all who investigated them, that they had started from very small beginnings. These beginnings at first were merely a subtle shift in emphasis of the basic attitude of physicians that started with the acceptance of the attitude basic in the euthanasia movement that there is such a thing as a life not worthy to be lived."

But, I have to ask: Is the attitude that a life is only worthwhile if I can profit from it, the same or worse than the attitude of a "life not worthy to be lived?"